

Case Number:	CM14-0117295		
Date Assigned:	08/06/2014	Date of Injury:	03/10/2014
Decision Date:	09/30/2014	UR Denial Date:	07/18/2014
Priority:	Standard	Application Received:	07/25/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 46 year old male with a 3/10/2014 date of injury. The exact mechanism of the original injury was not clearly described. A progress report dated 7/8/14 noted subjective complaints of neck, back, and left shoulder pain. Objective findings included cervical, thoracic, and lumbar spine tenderness. There was decreased motor strength 4/5 left shoulder and left lower extremity. MRI cervical spine showed 2-3 mm disc bulges, facet arthropathy, and mild narrowing of the neural foramen. MRI lumbar spine had disc bulging without evidence of canal or foraminal stenosis. Diagnostic Impression: cervical strain, lumbar strain, left shoulder strain. Treatment to Date: physical therapy, medication management. A UR decision dated 7/18/14 denied the request for urinalysis. The documentation does not outline this patient to be on oral opioid medication for which UDS would be necessary. It also denied functional capacity evaluation (FCE). Guideline criteria have not been met. It also denied EMG/NCV of the bilateral upper extremities. There are no documented red flag findings to suggest peripheral nerve entrapment. It also denied EMG/NCV of the bilateral lower extremities. There are no documented red flag findings to suggest peripheral nerve entrapment. It also denied lumbosacral brace. Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. It also denied interferential unit (IF). Guideline criteria have not been met. It also denied hot/cold unit. Routine use of cryotherapies in health care provider offices or home use of high-tech devices for the treatment of LBP is not recommended. It also denied physical therapy two (2) times six (6) for cervical spine, thoracic spine, lumbar spine, and left shoulder. There is no documentation of musculoskeletal deficits that cannot be addressed with home exercise. It also denied Gabapentin 10%, Amitriptyline 10%, Dextromethorphan 10% topical 30 gm. Topical antiepilepsy drugs are not supported by CA MTUS. It also denied Flubriprofen 20%, Tramadol

20% topical gel 30 gm. There is no clear rationale for the use of the requested topical Tramadol rather than the FDA approved oral form.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Urinalysis: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, screening for risk of addiction (tests). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter Urine Drug Testing (UDT).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 222-238, Chronic Pain Treatment Guidelines drug testing page 43, urine testing in ongoing opiate management page 78 Page(s): 43, 78.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that a urine analysis is recommended as an option to assess for the use or the presence of illegal drugs, to assess for abuse, to assess before a therapeutic trial of opioids, addiction, or poor pain control in patients under on-going opioid treatment. However, in review of the provided documents, there is no mention that the patient is on opioid therapy or any plan to initiate opioid therapy. Also, there is no notion of concern for illegal drug use. Furthermore, there is a UDS from 4/25/14 that was entirely negative. It is unclear why the patient would need a repeat urine drug screen. Therefore, the request for urinalysis was not medically necessary.

Functional Capacity Evaluation (FCE): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty Chapter, functional capacity evaluation (FCE) chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) chapter 7 Independent Medical Examinations and Consultations page 132-139 Official Disability Guidelines (ODG) fitness for duty chapter, FCE.

Decision rationale: CA MTUS states that there is little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace; an FCE reflects what an individual can do on a single day, at a particular time, under controlled circumstances, that provide an indication of that individual's abilities. In addition, ODG states that an FCE should be considered when case management is hampered by complex issues (prior unsuccessful RTW attempts, conflicting medical reporting on precautions and/or fitness for modified job), injuries that require detailed exploration of a worker's abilities, timing is appropriate (Close to or at MMI/all key medical reports secured), and additional/secondary conditions have been clarified. However, in the provided documents, there is no mention of prior unsuccessful RTW or

conflicting reports on job precautions. It is unclear what an FCE would achieve. Therefore, the request for functional capacity evaluation (FCE) was not medically necessary.

Electromyography (EMG) of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter.

Decision rationale: CA MTUS criteria for EMG/NCV of the upper extremity include documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment. However, in the provided documents, there is no clear documentation of a failure of conservative therapy such as physical therapy. Therefore, the request for electromyography (EMG) of the bilateral upper extremities was not medically necessary.

Nerve Conduction Velocity (NCV) of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Official Disability Guidelines (ODG) neck and upper back chapter.

Decision rationale: CA MTUS criteria for EMG/NCV of the upper extremity include documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment. However, in the provided documents, there is no clear documentation of a failure of conservative therapy such as physical therapy. Therefore, the request for Nerve Conduction Velocity (NCV) of the bilateral upper extremities was not medically necessary.

Electromyography (EMG) of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) for Low Back Chapter, EMGs (electromyography) and nerve conduction studies (NCS) sections.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter.

Decision rationale: CA MTUS states that electromyography (EMG), including H-reflex tests, are indicated to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. In addition, ODG states that EMGs may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. Furthermore, NCS are not recommended when a patient is presumed to have symptoms on the basis of radiculopathy. However, in the documents provided for review, there is no mention of aggressive conservative therapy such as physical therapy. Therefore, the patient cannot be said to have failed conservative measures. Therefore, the request for electromyography (EMG) of the bilateral lower extremities was not medically necessary.

Nerve Conduction Velocity (NCV) of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) for Low Back Chapter, EMGs (electromyography) and nerve conduction studies (NCS) sections.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter.

Decision rationale: CA MTUS states that electromyography (EMG), including H-reflex tests, are indicated to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. In addition, ODG states that EMGs may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. Furthermore, NCS are not recommended when a patient is presumed to have symptoms on the basis of radiculopathy. However, in the documents provided for review, there is no mention of aggressive conservative therapy such as physical therapy. Therefore, the patient cannot be said to have failed conservative measures. Therefore, the request for nerve conduction velocity (NCV) of the bilateral lower extremities was not medically necessary.

Lumbosacral brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter.

Decision rationale: CA MTUS states that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief; however, ODG states that lumbar supports are not recommended for prevention; as there is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. They are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented

instability, and for treatment of nonspecific LBP as a conservative option. However, given the patient's 3/14 original date of injury, he is far removed from the acute phase of symptom relief. There is no evidence that a lumbar support would be of benefit to him at this time. Therefore, the request for lumbosacral brace was not medically necessary.

Interferential Unit (IF): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL THERAPY Page(s): 118-120.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that a one-month trial may be appropriate when pain is ineffectively controlled due to diminished effectiveness of medications; or pain is ineffectively controlled with medications due to side effects; or history of substance abuse; or significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or unresponsive to conservative measures. However, there is no clear documentation that the patient meets any of these criteria. Furthermore, there has not been any documentation of failure of conservative measures such as physical therapy. Therefore, the request for interferential unit (IF) was not medically necessary.

Hot/Cold Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ACOEM Practice Guidelines 2nd edition, Low Back Disorders Chapter (update to Chapter 12).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: (http://www.aetna.com/cpb/medical/data/200_299/0297.html).

Decision rationale: MTUS supports passive heat and cold therapy to reduce inflammation and increase blood supply. However, MTUS does not support the use of heat/cold therapy units with mechanically circulating pumps. Aetna considers passive hot and cold therapy medically necessary. Mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. There is no evidence that hot/cold therapy unit is more effective than passive hot and cold therapy. Therefore, the request for Hot/Cold Unit was not medically necessary.

Physical Therapy two (2) times six (6) for cervical spine, thoracic spine, lumbar spine, and left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL THERAPY Page(s): 98-99. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Pain, Suffering, and the restoration of function chapter 6 page 114.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines support an initial course of physical therapy with objective functional deficits and functional goals. However, in the provided documents there is no objective evidence of any significant functional deficits that would substantiate the need for a course of physical therapy. It is unclear what functional goals could be achieved with this treatment modality. Therefore, the request for physical therapy two (2) times six (6) for cervical spine, thoracic spine, lumbar spine and left shoulder was not medically necessary.

Gabapentin 10%, Amitriptyline 10%, Dextromethorphan 10%, topical 30Gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Boswellia Serrata Resin, Capsaicin, Topical Analgesics Page(s): 25, 28, 111-113.

Decision rationale: Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many these agents. CA MTUS Chronic Pain Medical Treatment Guidelines state that Ketoprofen, Lidocaine (in creams, lotion or gels), capsaicin in anything greater than a 0.025% formulation, Baclofen, Boswellia Serrata Resin, and other muscle relaxants, and Gabapentin and other antiepilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. MTUS states that Gabapentin is not recommended topically, and any compounded product that contains at least one drug that is not recommended is not recommended. Therefore, the request for Gabapentin 10% Amitriptyline 10% Dextromethorphan 10% topical 30 gm was not medically necessary.

Flurbiprofen 20%, Tramadol 20% topical gel 30Gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

Decision rationale: Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many these agents. CA MTUS Chronic Pain Medical Treatment Guidelines state that Ketoprofen, Lidocaine (in creams, lotion or gels), capsaicin in anything greater than a 0.025% formulation, Baclofen, Boswellia Serrata Resin, and

other muscle relaxants, and Gabapentin and other antiepilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. MTUS and ODG guidelines do not currently support the use of topical Flurbiprofen. Additionally, any compound product that contains at least one drug that is not recommended is not recommended. Therefore, the request for Flurbiprofen 20%, Tramadol 20% topical gel 30 gm was not medically necessary.